

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED FEB 24 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

457

301

Registration District No. 791

Primary Registration District No. 100

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St. Marys Hosp. Infirmary  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 months (Specify whether years, months or days)  
In this community 2 months

3. (a) PRINT FULL NAME W<sup>m</sup>. T. JONES

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race colored 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Bertha Jones 6. (c) Age of husband or wife If alive 43 years  
7. Birth date of deceased Jan. 2 1881  
(Month) (Day) (Year)

8. AGE: Years 61 Months - Days 7 If less than one day hr. min.

9. Birthplace Madison County Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business Tavern Owner  
12. Name Dalk. Jones  
13. Birthplace Madison Co. Miss.  
(City, town, or county) (State or foreign country)  
14. Maiden name Betty Brown  
15. Birthplace Madison Co. Miss.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bertha Jones  
(b) Address Madison Co.

17. (a) Burial (b) Date thereof Jan. 13-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Hosp. Infirmary

18. (a) Signature of funeral director J. Marshall  
(b) Address 225 N. 2nd St. St. Louis

19. (a) JAN 11 1942 (b) J. B. Redick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County Madison  
(c) City or town Madison  
(If outside city or town limits, write "RURAL")  
(d) Street No. 901 Madison St. 2  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 999 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9  
year 1942 hour 2 minute 20 P. M.

21. I hereby certify that I attended the deceased from OCT. 31, 1941, to Jan 9, 1942  
that I last saw him alive on JAN 9, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Stomach Duration 3 mos.

Due to unknown

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature W. H. Jones (M. D. or other) M.D.  
Address St. Louis Date signed 1-10-42

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....,  
working under my personal supervision.

Signed.....

*Lyda Hughes*

Licensed Embalmer No. *2938*

P. O. Address.....

*St Louis mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.